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BUSINESS MANAGER . . . . JOHN HUNTON

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This leaflet will be sent to any member of the California Medical Association desiring it.

Contributions of "Letters to the Editor," News and Notes, and Antispasmodics:

The Editorial Board will be glad to receive and consider for publication letters containing information of general interest to physicians throughout the State or presenting constructive criticisms on controversial issues of the day. Also News and Notes items regarding the affairs and activities of hospitals, individuals, communities and local medical societies and groups throughout the State, as well as material in the lighter vein.

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(County society secretaries are requested to notify "California Medicine" promptly when changes are indicated in their roster information.)

ALAMEDA County Medical Association
364 14th Street, Oakland 12
President, Theodore C. Lawson, 3135 Webster Street, Oakland 9.
Secretary, Dorothy M. Allen, 2923 Webster Street, Oakland 9.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

BUTTE-GLENN County Medical Society
President, J. G. Hepplewhite, Chico
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

CONTRA COSTA County Medical Society
President, H. W. McNerney, 2600 MacDonald Avenue, Richmond
Secretary, George D. Husser, 322 Twenty-third Street, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

FRESNO County Medical Society
President, E. A. Patterson, P. O. Box 1908, Fresno.
Secretary, William N. Knudsen, 701 T.W. Patterson Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

HUMBOLDT County Medical Society
President, Walter Dolfini, 539 G Street, Eureka.
Secretary, Wayne P. McKee, Ferndale.
Meeting, *First Thursday.*

IMPERIAL County Medical Society
President, Charles Cutshaw, Brawley.
Secretary, George Cole, Brawley.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

INYO-MONO County Medical Society
President, Walter L. Wilson, 108 N. Main, Bishop.
Secretary, Lloyd S. Bambauer, Bishop.
Meeting, *Fourth Wednesday, except December, January, February.*

KERN County Medical Society
President, William H. Macdonald, 2103 18th Street, Bakersfield.
Secretary, Frederick O. Wynia, 354 Haberfelde Building, Bakersfield.
Meeting, *Third Tuesday, 7:30 p. m., Stockdale Country Club, except June, July, August.*

KINGS County Medical Society
President, Allen Stamler, Corcoran.
Secretary, William F. Chamlee, Van Sicklen Building, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

LASSEN-PLUMAS-MODOC County Medical Society
President, Wilbur C. Batson, Greenville.
Secretary, John Paul McKenney, Alturas.
Meeting, *On Call.*

LOS ANGELES County Medical Association
1925 Wilshire Boulevard, Los Angeles 5
President, E. T. Remmen, 429 North Orange, Glendale 3.
Secretary, Carl L. Mulfinger, 1052 West Sixth Street, Los Angeles 14.
Meeting, *First and Third Thursday, 1925 Wilshire Boulevard, Los Angeles.*

MARIN County Medical Society
President, Ernest W. Denicke, 1010 B Street, San Rafael.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 7:00 p. m., Travelers Inn, San Rafael.*

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President, Clemens M. Beil, Upper Lake
Secretary, E. C. Bennett, Ukiah.

MERCED County Medical Society
President, E. R. Fountain, Merced.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

MONTEREY County Medical Society
President, A. L. Wessels, 11 Maple Street, Salinas.
Secretary, F. H. Smith, Salinas National Bank Building, Salinas.
Meeting, *First Thursday.*

NAPA County Medical Society
President, Charles H. Bulson, 1203 Seminary Street, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

ORANGE County Medical Association
President, John Montanus, Rt. 1, Box 587A, Santa Ana.
Secretary, Llewellyn E. Wilson, 502 Bank of America Building, Anaheim.
Meeting, *First Tuesday, 7:00 p. m., Windsor Cafe, Santa Ana.*

PLACER - NEVADA - SIERRA County Medical Society
President, George A. Foster, Grass Valley.
Secretary, Vernon W. Padgett, Grass Valley.
Meeting, *At Call of President.*

RIVERSIDE County Medical Association
President, Franklyn D. Hankins, 3014 Pine Street, Riverside.
Secretary, Cecil Lord, 3616 Main Street Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

SACRAMENTO Society for Medical Improvement
President, Dudley Saeltzer, Medico-Dental Building, Sacramento.
Secretary, Edmund E. Simpson, 1127 Eleventh Street, Sacramento 14.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

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President, J. M. O'Donnell, Hollister.
Secretary, J. J. Haruff, Hollister.
Meeting, *At Call of President.*

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President, Marcus D. White, 201 Fallas Building, Ontario.
Secretary, Thomas F. Dempsey, 1272 E Street, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

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President, F. E. Jacobs, 4228 El Cajon Boulevard, San Diego 5.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego, 1.
Meeting, *Second Tuesday, San Diego Club.*

SAN FRANCISCO County Medical Society
2180 Washington Street 9
President, Anthony B. Diepenbrock, 2180 Washington Street, San Francisco 9.
Secretary, Robertson Ward, 2180 Washington Street, San Francisco 9.
Meeting, *Second Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco 9.*

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President, Dora Ames Lee, 110 North San Joaquin Street, Stockton 6.
Secretary, H. D. Chope, Box 111, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

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President, H. N. Cookson, 154 Traffic Way, Arroyo Grande.
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Meeting, *Third Saturday, 7:00 p. m., Gold Dragon Cafe, San Luis Obispo.*

SAN MATEO County Medical Society
President, Stuart Lindsay, 440 Portola, San Mateo.
Secretary, Albert G. Miller, Medical Arts Building, San Mateo.
Meeting, *Third Tuesday of each month.*

SANTA BARBARA County Medical Society
President, D. H. McNamara, Cottage Hospital, Santa Barbara.
Secretary, Douglas F. McDowell, 317 W. Pueblo Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

SANTA CLARA County Medical Association
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Secretary, Leslie B. Magoon, 630 E. Santa Clara, San Jose 12.

SANTA CRUZ County Medical Society
President, Luther Newhall, Jr., Ocean and Broadway, Santa Cruz
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *Every second month, second Tuesday. Time and place to be announced.*

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President, L. C. Mosher, Bieber.
Secretary, Julius M. Kehoe, Redding.
Meeting, *Second Monday.*

SISKIYOU County Medical Society
President, Richard W. Jones, 106 South Broadway, Yreka.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

SOLANO County Medical Society
President, H. Randall Madeley, 727 Sonoma Street, Vallejo.
Secretary, Charles H. Widenmann, 405 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo; Hotel Vallejo.*

SONOMA County Medical Society
President, Wilson Stegeman, 534 B Street, Santa Rosa.
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Meeting, *Second Thursday.*

STANISLAUS County Medical Society
President, Andrew Van De Pol, P. O. Box 944, Modesto.
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Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

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Meeting, *At Call of President.*

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Secretary, Emery Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

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President, John W. Scott, Colusa.
Secretary, Leon M. Swift, Box 244, Marysville.
Meeting, *Second Wednesday.*

(For roster of C.M.A. committees and other organizations, see last month's issue.)

ANTISPASMODICS

He'll let you thumb through a catalog picturing a variety of homes, while he turns on the charm with a persuasive sales talk. He'll grow eloquent on the relative merits of door chimes and attached garages. If you're hard to convince, he may even take you around to see one of his homes that's already built.—*From "Is There a Prefab in Your Future?" in Better Homes and Gardens.*

We're already convinced. We'd rather have the garage.

Opening game ceremonies will be stripped to the barest non-essentials.—*From the San Francisco Call-Bulletin.*

O.K., but let's not leave out the game.

REASONABLE BIAS

My friend Bill and I, both bald, had a mutual acquaintance whom I liked and Bill did not. Indeed Bill never missed a chance to disparage when our acquaintance's name came up in conversation, and once on the occasion of an unusually vituperative outburst of this sort, I was moved to protest that I rather liked the fellow. "What," I asked, "have you got against him?"

Bill looked blank for a moment, then contemplative. At last he smiled triumphantly and said: "Why, the so-and-so has all his hair!"

Girl (at bathing beach): Aren't you a little heavier than you were last year?

Man: Yes, I've added another growth ring since last year.

COUNTY SOCIETIES

CHANGES IN MEMBERSHIP

New Members (179)

Alameda County (14)

Bowles, Frank H., Jr., *Oakland*
Goetz, Franz R., *Oakland*
Goggio, Alfred E., *Berkeley*
Howell, Homer P., *Oakland*
Kirksey, Morris M., *Livermore*
Lewis, Leon, *Berkeley*
Mitchell, Gertrude M., *Oakland*
Muller, Harold P., *Berkeley*
Norcross, Nathan G., *Oakland*
Owyang, Edwin, *San Leandro*
Smith, Samuel Warren, *Berkeley*
Thomas, Robert L., *Oakland*
Vasko, John R., *Oakland*
Wolfe, Alfred M., *Oakland*

Butte-Glenn County (4)

Cheek, David B., *Chico*
Chernow, Marvin, *Chico*
Colm, C. Leland, *Chico*
Newman, Harold, *Chico*

Contra Costa County (3)

Bigger, Ralph W., *Walnut Creek*
Pederson, L. A., *Richmond*
Rea, Walter J., *Martinez*

Fresno County (2)

Rohlfing, Walter A., *Fresno*
Smith, W. Jewell, *Fresno*

Humboldt County (3)

Goble, Garvin, *Fortuna*
Jarvis, Shiras M., *Eureka*
Poska, T. A., *Eureka*

Kern County (4)

Grove, Howard, *Bakersfield*
Lambeth, George S., *Bakersfield*
Sanden, A. O., *McKittrick*
Yeisley, C. J., *Bakersfield*

Kings County (1)

Jacob, Harold G., *Corcoran*

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Arcadi, Vittorio C., *Whittier*
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Hein, Richard James, *Los Angeles*
Hodel, George Hill, *Los Angeles*
Howell, Jennie M., *Los Angeles*
Gilbert, Roy O., *Sherman Oaks*
Hutner, Laurence M., *Beverly Hills*
Ingham, Harrington V., *Los Angeles*
Ingle, Vernon A., *Montebello*
Kieffer, John P., *Los Angeles*
Madden, Earl E., *Redondo Beach*
Madoff, Irving, *Los Angeles*
Mudry, Joseph, *San Pedro*
Mueller, Rudolph R., *Los Angeles*
Nierenberg, Harry N., *Beverly Hills*
Petersen, Arnold L., *Lynwood*
Polmeteer, F. E., *Long Beach*
Reina, Solomon de la, *Manhattan Beach*
Rome, Sol., *Los Angeles*

(Continued on Page 16)

COUNTY SOCIETIES
CHANGES IN MEMBERSHIP

(Continued from Page 12)

Romonek, Philip L., *Beverly Hills*
Schreiber, Louis W., *Beverly Hills*
Sobin, David J., *Hollywood*
Stearns, A. L., *North Hollywood*
Todd, Malcolm C., *Long Beach*

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Hurlbut, J. Lyman, *Larkspur*

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Siders, R. C., *Fort Bragg*

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Hall, Gordon, *Salinas*
Husser, Horace F., *Salinas*

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Douglas, Earl W., *Imola*
Priest, Ethel Humphreys, *Napa*
Weir, Irvin N., *St. Helena*

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Dameron, Milton H., *Anaheim*
Durm, Thomas I., *Buena Park*
Gardner, William C., *Santa Ana*

(Continued on Page 17)

COUNTY SOCIETIES CHANGES IN MEMBERSHIP

(Continued from Page 16)

Merryman, George H., Jr., *Santa Ana*
Miller, John E., *Anaheim*
Roberts, B. D., *Anaheim*

Placer-Nevada-Sierra County (2)

Angella, Carl, *Roseville*
Ballou, John M., *Grass Valley*

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Ballard, Ross L., *Needles*
Benjamin, E. L., *San Bernardino*
Bonar, Barnet E., *Trona*
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Gutekunst, F. W., *San Bernardino*
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Honor, Herbert C., *Loma Linda*
Loeb, Edward A., *Fontana*
Matthews, Norman E. W., *Loma Linda*
Milligan, Bruce W., *Needles*
Orr, Horace D., *Victorville*
Snow, Virgin C., *Fontana*
Thumma, Ralph W., *San Bernardino*
Vickers, James E., *Etiwanda*

San Diego County (21)

Bethard, W. F., *Coronado*

(Continued on Page 20)

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CHANGES IN MEMBERSHIP

(Continued from Page 17)

Day, Roy W., *San Diego*
Doemeny, E. P., *San Diego*
Findeisen, William Ernest, *Coronado*
Fisher, Harold L., *Mission Beach*
Franklin, Glenn C., *San Diego*
Graves, Clifford L., *San Diego*
Hartley, George, Jr., *San Diego*
Hjartarson, G. D., *San Diego*
Hyde, C. R., *La Jolla*
McGowan, J. P., *La Jolla*
Pace, J. Blair, *Carlsbad*
Pickering, P. P., *San Diego*
Randolph, C. E., *El Cajon*
Roskos, Andrew T., *San Diego*
Sauer, W. Nicholas, *San Diego*
Singer, David, *San Diego*
Smollar, Leo, *San Diego*
Stewart, M. J., *San Diego*
Strayer, Webster, *San Diego*
Weigle, Edward H., *San Diego*

San Francisco County (24)

Breslow, Lester, *San Francisco*
Carlsmith, Margaret E., *San Francisco*
Divanovich, David, *San Francisco*
Evans, Robert S., *San Francisco*
Fasal, Elfriede, *San Francisco*
Fasal, Paul, *San Francisco*
Foote, Robert F., *Corona*
Fischer, Golda, *San Francisco*
Franklin, Harold J., *San Francisco*

(Continued on Page 22)

COUNTY SOCIETIES CHANGES IN MEMBERSHIP

(Continued from Page 20)

Glover, Mary E., *San Francisco*
Hagen, Kenneth R., *San Francisco*
Hilgard, Josephine R., *San Francisco*
Lofgren, Robert C., *San Francisco*
Merrill, Bruce R., *San Francisco*
Misrack, Maury L., *San Francisco*
Scarlett, Samuel L., *San Francisco*
Sherman, Julius, *San Francisco*
Siegel, Arthur, *San Francisco*
Stuart, Margaret Moore, *San Francisco*
Thomas, William McKinley, *San Francisco*
Viguie, George C., *San Francisco*
Vollert, Edward F., *San Francisco*
Welke, Elton G., *San Francisco*
Wooten, Betsy G., *San Francisco*

San Joaquin County (6)

Cossentine, Robert E., *Stockton*
Cove, Arthur M., *Stockton*
Gianelli, Virgil, *Stockton*
Hefferman, James J., *Stockton*
Mayo, John F., *Lodi*
Plageman, William H., *Stockton*

San Luis Obispo County (2)

Bearg, Philip A., *San Luis Obispo*
Tepper, Helen, *San Luis Obispo*

San Mateo County (3)

Flanders, Jackson, *Redwood City*

(Continued on Page 24)

COUNTY SOCIETIES CHANGES IN MEMBERSHIP

(Continued from Page 22)

Maloney, Joseph M., *San Carlos*
Wanless, Loren E., *San Mateo*

Santa Barbara County (3)

Allen, William H., *Santa Barbara*
Caldwell, David M., *Santa Barbara*
Lambert, Richard, *Santa Barbara*

Santa Clara County (5)

Anderson, John L., *Mountain View*
McElligott, E. W., *San Jose*
McElmurry, N. K., *San Jose*
Mott, John M., *Campbell*
Sears, William Norman, *Palo Alto*

Santa Cruz County (3)

Dixon, H. R., Jr., *Watsonville*
Nittler, Alan H., *Santa Cruz*
Steele, Ashby, *Santa Cruz*

Solano County (3)

Gibbons, R. Matthew, *Vallejo*
Lewis, W. B., *Vallejo*
Thelin, H. M., *Vacaville*

Sonoma County (10)

Barbour, Benjamin Rogers, *Santa Rosa*
Clary, David T., *Guerneville*
Dyer, Harold L., *Santa Rosa*
Johnston, Russell C., *Santa Rosa*
Kenney, John M., *Santa Rosa*
Levinson, Herman, *Santa Rosa*
Mikita, Michael M., *Sonoma*
Mohrman, John J., *Petaluma*
Kroger, O. C., *Healdsburg*
Orsborn, Ernest V., *Santa Rosa*

Stanislaus County (1)

Nachtman, Howard F., *Modesto*

Tehama County (1)

Thorpe, H. Harper, *Red Bluff*

Tulare County (2)

Raymond, J. R., *Dinuba*
Roessler, B., *Visalia*

Transfers (25)

Brink, H. E., from *Sonoma County* to *Santa Clara County*
Daniels, Albert C., from *Marin County* to *San Francisco County*
Eichwald, Max, from *San Francisco County* to *Butte-Glenn County*
Grayson, Charles, from *San Francisco County* to *Sacramento County*
Hayden, Charles T., from *San Francisco County* to *Alameda County*
Hoag, Carl L., from *San Francisco County* to *San Mateo County*
Johnson, Karl, from *Kings County* to *Kern County*
Kelley, Edwin Hal, from *San Diego County* to *Placer-Nevada-Sierra County*
McGowan, Donald O., from *Los Angeles County* to *Sacramento County*
Needles, Johhn W., from *Santa Barbara County* to *Los Angeles County*
Nickels, Thomas T., from *San Francisco County to Alameda County*

(Continued on Page 28)

COUNTY SOCIETIES CHANGES IN MEMBERSHIP

(Continued from Page 24)

Nunes, Aubrey J., from *Sonoma County* to *Monterey County*

Pierce, Richard K., from *San Francisco County* to *San Bernardino County*

Prescott, Walton, from *Alameda County* to *Placer-Nevada-Sierra County*

Reider, Norman, from *Los Angeles County* to *San Francisco County*

Reinertsen, B. R., from *Los Angeles County* to *Contra Costa County*

Roe, Harold E., from *Alameda County* to *San Bernardino County*

Rosenvold, Lloyd K., from *Los Angeles County* to *San Bernardino County*

Sears, Adrian R. M., from *San Francisco County* to *Butte-Glenn County*

Sickafoose, Harry R., from *Los Angeles County* to *Orange County*

Sevener, Clinton J., from *Los Angeles County* to *Napa County*

Siemens, John C., from *Monterey County* to *Marin County*

Stocker, Howard, from *Los Angeles County* to *Santa Barbara County*

Tipton, Dean, from *Ventura County* to *Placer-Nevada-Sierra County*

Toller, R. B., from *Mendocino-Lake County* to *San Joaquin County*

HEART DISEASE STILL LEADS AS CAUSE OF DEATH AMONG DOCTORS

Death claimed approximately 3,558 physicians during 1946 as compared with 4,015 the previous year, according to the January 11 issue of *The Journal of the American Medical Association.*

On the basis of an analysis of 3,358 obituaries published in *The Journal* during the year, it was found that the average age at death was 66.1 as compared with 65.3 in 1945. The majority of the physicians—584—died between the ages of 70 and 74, the same age group that was dominant in 1945.

Heart disease remains the leading cause of death among physicians. Coronary thrombosis and occlusion accounted for 738 deaths (655 in 1945), 283 occurring between the ages 60 and 69. Cerebral hemorrhage, thrombosis and embolism accounted for 404 deaths; cancer and tumors were responsible for 352 deaths and pneumonia for 199. Tuberculosis caused 31 deaths, asthma 10, bronchitis and pleurisy five, and other diseases of the resporatory system 31.

The Journal finds significant the total of 55 suicides as compared with the 25 recorded for 1945. Twenty-four were the result of bullet wounds, nine of drugs and five each of cut arteries and poison. There were 130 accidental deaths, 55 of which involved automobiles.

One automobile accident occurred in a collision with a train and one with a street car. Four deaths were attributed to x-ray accidents and complications. Of the unusual accidents one physician was killed by a bolt of lightning while playing golf, one died of injuries received when he fell under the wheels of a mule drawn wagon, one when a tractor he was driving overturned and one when

(Continued on Page 38)

HEART DISEASE STILL LEADS AS CAUSE OF DEATH AMONG DOCTORS

(Continued from Page 34)

a broken power cable wire struck him over the head; one died in a Chicago hotel fire.

Among the decedents were 274 who had been teachers in medical schools, of whom 122 had reached professorial status. There were seven deans, one president of a high school, one vice president of a medical school, one teacher in a public school and 122 membesr of education boards. One hundred and sixty-nine had been health officers, 108 members of boards of health, 67 coroners, 51 mayors, 31 authors, 29 members of medical examining boards, 27 bank presidents, 27 legislators, 26 pharmacists, 16 editors, 12 missionaries, eight dentists, seven postmasters, four lawyers and three interns.

Decedents included a vice president of the American Medical Association, one charter member of a council, four chairmen of councils and 13 section officers. Thirty-four had been members of the House of Delegates and one Speaker of the House. There were 35 presidents of state medical societies, four secretaries of state societies and 216 who had been presidents of county medical societies.

The 3,358 *Journal* obituaries included 40 physicians who were killed in action during World War II and 128 who died while in military service. A number of those who were killed in action had first been reported missing in action. Eight physicians lost their lives in the Asiatic area, seven in the Philippine Islands, six in the China Sea, five in Germany, five in the Pacific area, two in Italy, two in France and one each in Formosa, Luzon, North African area, Okinawa and Tinian. Nine were reported as prisoners of war.

Of the 128 physicians who died while in military service,

(Continued on Page 42)

HEART DISEASE STILL LEADS AS CAUSE OF DEATH AMONG DOCTORS

(Continued from Page 38)

coronary thrombosis caused 19 of the 29 deaths attributed to various forms of heart disease. Airplane accidents caused 16 deaths and automobile accidents nine. Cancer was responsible for 10 deaths, three of which were brain tumors. The remaining deaths were from miscellaneous causes.

The 40 deaths classified as killed in action give an average age of 35.2, while the average for the 128 who died while in military service is 42.8. Combining the two, an average of 37.7 is recorded.

Since the outbreak of World War II on Dec. 7, 1941, *The Journal* has recorded the deaths of 257 physicians who were killed in action and 501 who died while in military service. Reports still being received by *The Journal* indicate that the aggregate total of 758 military deaths among physicians will be greatly augmented when the complete statistics are made available through official military channels.

Napoleon Bonaparte (1769-1821).—Largely mythical is the "iron health" of Napoleon; it was his iron will that surmounted physical defects. Certain it is that Napoleon since early childhood had suffered from gastric disorders, and it is said that "gastric spasm" accounted for his hesitancy to attack at a crucial moment during the battle of Leipzig. Physical disability likewise may explain his vacillation at the fateful battle of Waterloo. It is generally agreed that Napoleon died of cancer of the stomach.—Warner's *Calendar of Medical History.*

PNEUMONIA FOLLOWING CHEST INJURY PREVENTABLE WITH PENICILLIN

Pneumonia, following injury to the chest, can be prevented with large doses of penicillin or sulfadiazine, according to Edward Phillips, M.D., of Oakland, Calif.

Writing in the January 18 issue of *The Journal of the American Medical Association,* Dr. Phillips presents his observations on 73 patients treated at Permanente Foundation Hospital for pneumonia following injury to the chest.

Of these 73 patients, 43 had fractured ribs, one had a fractured shoulder blade and one had a fractured breast bone.

The author cites two investigators who demonstrated by animal experimentation how a blow to the chest, with or without fracture of the ribs, can produce injury to the lungs. The blow stimulates the vagus nerve, which extends from the cranium to the lungs, to contract the bronchial tubes which results in a partial collapse of the lung. This collapse area becomes infected because it lacks aeration.

Injections of atropine into the veins, which paralyzes the terminal fibers of the vagus nerve, will prevent or minimize the chances of collapse and infection following injury to the chest, states the author. Large doses of penicillin and sulfadiazine will sterilize the lung area.

Additional facts regarding the 73 patients follow:

In 54 patients (74 per cent) pneumonia developed only on the same side as the injury.

The majority of patients had a mild type of pneumonia.

Over 92 per cent of pneumonia cases occurred within six days of the injury.

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MEDICINE'S CHALLENGE*

S. J. McCLENDON, M.D., *San Diego*

DURING each annual session of the California Medical Association it is the duty of its President to make an address. In compliance with that duty, I shall endeavor to inform you concerning the accomplishments of the Association during this year past together with our failures and shortcomings. Also, to outline for you my own and our officers' suggestions concerning our future program.

The past year has been a transition year from war-time tension and work to peace-time activities. Many of our colleagues have returned from military duty and have reestablished themselves in private practice. The teaching universities and the California Medical Association have cooperated generously and effectively in providing post-graduate and refresher courses for our returned veteran physicians.

California, with a population of nine and one-half million persons, has confronting it many problems concerning the private practice of medicine and the public health of its citizens. If population analysts are correct, by 1960 the state will have a population of fifteen million. This rapid increase will mean that our state will develop into an industrialized society instead of an agricultural one. These changes will increase our problem with reference to the control of disease from the standpoint of private practice and public health.

During the past year, the medical profession in this state has again been faced with a distinct legislative threat of socialized or political medicine. This move on the part of the social planners, job creators and politicians is directly contrary to our concept of American democracy and the thoughts behind the founders of our country in the promulgation of the Constitution of the United States of America. The thought has, unfortunately, been by propaganda instilled into the minds of our citizens that a generous government must care for all of us from the cradle to the grave. The regimentation of the profession of medicine and its allied professions which would result from the socialization of the state or federal government from a medical standpoint would be contrary to all ideas of American freedom of action and enterprise. It would lead inevitably to totalitarianism and communism. The reasons for such a statement are many; one or two will suffice.

First: The acceptance of political medicine by our legislators and the public is a first step in our loss of individual rights — a step toward definite control of the daily lives and work of our citizens which must lead to federal and state control of all other professions and businesses. It seems fantastic that a people such as ours should ever seriously consider such proposals. However, many organizations and groups, by superb salesmanship, stressing security and distribution of services, are fostering such a system of medicine. When a government by law decides what physician a citizen may have, how much that physician may charge him and what kind of treatment he may have, that government will soon decide what all other trades and professions may do, in a similar manner. This would lead us into a nation of people looking to our state or federal government for guidance and sustenance in all phases of life itself.

Second: The statement that socialized medicine will provide better care than at present is based on false premises. In fact, from actual statistics and information from all the areas where state or federal medicine has been in force, it is definitely proven that good medical care such as we have is not possible under such conditions. State control and compulsion will absolutely lower the quality of medical care. Such control would not be economical. In this state to render good medical care to all the people would cost at least $600,000,000 to

* Address of the President, California Medical Association, delivered before the Seventy-sixth Annual Session, April 30, 1947, Los Angeles.

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EDITORIALS

Coronary Insufficiency

The concept of coronary insufficiency has evolved over recent years in concert with the appreciation of the importance of *dynamic* functional equilibria in physiological processes. The strictly anatomic structural abnormalities disclosed by the minute pathologic studies of the Virchow school of pathologists, while of great importance, have failed to explain many clinical phenomena observed during life. The absolute, *static* degree of abnormality, whether noted in the concentration of an electrolyte as an isolated finding, the venous pressure at rest, or the amount of coronary arteriosclerosis found at autopsy, does not reflect the functional effects of such abnormality on the organism as a whole. It is necessary to relate such abnormalities to the working individual in physiologic balance.

The concept of coronary insufficiency is, therefore, a physiologic concept, one that relates not alone to the degree of coronary arterial lesion, or to the size of the heart as such, but to the *balance* between blood flow in the coronary arteries and the need of the myocardium for blood. Whenever the requirement of the myocardium for oxygenated blood exceeds the flow of blood to the myocardium at any given instant, a state of coronary insufficiency may be said to exist. A significant degree of coronary arteriosclerosis may exist without functional coronary insufficiency if the exertional demands on the heart are limited. On the other hand, a modest degree of coronary arteriosclerosis may be productive of functional coronary insufficiency when excessive work is demanded of the heart as in severe exertion or hyperthyroidism. If the work demanded of the heart is only moderate, and the degree of coronary arterial disease is modest, functional coronary insufficiency can result if the blood flowing through the coronary arteries is deficient in oxygen carrying hemoglobin as in severe anemia; or if the head of pressure responsible for the flow of blood through the coronary arteries is greatly reduced as in the hypotension of shock or tachycardia, or in aortic stenosis; or if the diastolic recovery of the heart is limited in rapid heart rates; or if the efficiency of the heart is reduced as in extra systoles and in cardiac irregularities without excessive rates. It is clear that the functional status of the coronary circulation is the resultant of many dynamic factors of which the most important are: (1) the degree of narrowing of the coronary arteries; (2) the size of the coronary capillary bed in relation to the size of the heart (there may be a relative disproportion in cardiac hypertrophy with normal coronary vessels); (3) the presence of anemia; (4) the presence of an abnormal metabolic rate; (5) the systolic head of pressure in the aorta; (6) the diastolic pressure; (7) the rate and regularity of the heart; (8) the work of the heart. It is apparent that strictly anatomic studies will not show adequate correlation with the functional limitations of the individual during life.

Various classifications of coronary insufficiency have been offered. That of Katz defines three groups: (1) acute transitory coronary insufficiency as in angina pectoris; (2) acute protracted coronary insufficiency, as in acute myocardial infarction; and (3) chronic insufficiency, as in progressive coronary disease with myocardial fibrosis and eventual cardiac failure. This classification is helpful and explains most examples of coronary insufficiency. Thus angina pectoris, or acute transitory coronary insufficiency, reflects the temporary disproportion between blood flow and cardiac metabolic needs induced by effort or severe emotion. When the disproportion continues, or coronary insufficiency is protracted, as in coronary occlusion, prolonged shock from any cause, large doses of epinephrine, etc., irreversible changes occur in the

CALIFORNIA MEDICAL ASSOCIATION

NOTICES AND REPORTS

E. Vincent Askey, M.D.—C.M.A. President-Elect

The demographer with his reams of statistics on population trends, the civil engineer with his data on the stress and strain of materials, and the corporation attorney with all manner of decisions at his finger-tips have much in common. They are dealing with abstract figures, useful and constructive, of course, but nevertheless, lifeless. Not so, the biographer. While he must perforce take refuge at times under the shelter of certain statements of fact, his primary concern lies in a presentation and interpretation of what might properly be termed the biographic dynamics of his subject. He asks and answers the question: "What makes this man stand out as a leader among his fellows?"

Dr. E. Vincent Askey was born in Sligo, Pennsylvania, where he received his early education in the public schools. Upon completion of the eighth grade, he moved with his family to Hoquiam, Washington, where he attended High School, graduating in 1913. Back in the East, he attended Allegheny College in Meadville, Pennsylvania, for four years, completing the course with the degree of Bachelor of Science in 1917. His under-graduate medical training was at the University of Pennsylvania where he obtained the degree of Doctor of Medicine in 1921. Internship and Residency were completed in Philadelphia.

He is a member of Alpha Omega Alpha honorary fraternity, Delta Tau Delta social fraternity and Nu Sigma Nu medical fraternity.

Dr. Askey's professional interests have always been in surgery, to which field he limits his work, having practiced in Los Angeles for over twenty years. He became a Fellow of the American College of Surgeons in 1929. He is married and the father of three children, one daughter and two sons.

A Methodist by early training and later inclination, Dr. Askey has been active in the Westwood Community Methodist Church, having for several years served as a Trustee in that organization.

So much for the mere perfunctory chronicling of biographical data. Now, for a look at the intangibles in his history which, as is so often the case, are of far greater importance in explaining why he should be chosen to lead the California Medical Association.

Early in his professional career, Dr. Askey became interested in civic affairs as well as in the economic phases of medical practice. He was a member of the Los Angeles School Board from 1937 to 1943, serving as that body's President during the year 1941. Sitting on that Board, he contributed much to the establishment of an improved curriculum and received in turn invaluable insight into an important phase of a State-regulated venture.

Medical organizations have always attracted him. He plunged wholeheartedly into the activities of the Los Angeles County Medical Association as its Secretary-Treasurer during the years 1935 to 1937, and served as its President in 1943. During the first three of the past six years, he was Vice-Speaker of the House of Delegates of the California Medical Association and during the past three years, he has been Speaker, taking a most active part in the deliberations of the Council and of the Executive Committee. To him is due credit for introducing before the Council a resolution calling for a thor-

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA

By FREDERICK N. SCATENA, M.D.
Secretary-Treasurer

Board Proceedings

The following changes were made in the status of licentiates of the Board of Medical Examiners at the meeting held March 10 to 13, 1947, at the Mayfair Hotel, Los Angeles.

Frederick Sheets Lorenz, M.D.—Found guilty of unprofessional conduct as defined in Section 2383 of the Business and Professions Code; License revoked. Order of revocation stayed and suspended for five years, and he was placed on probation with specified terms for said period of five years.

David Andrew Stevens, M.D.—Found guilty of unprofessional conduct as defined in Section 2383 of the Business and Professions Code; License revoked.

Leonard Dexter Wood, M.D.—Found guilty of unprofessional conduct in that he violated the provisions of Section 2411 of the Business and Professions Code: License suspended for one year and probation for ten years without narcotics.

Jean Nazareth Andrews, M.D.—License restored; Dr. Andrews was placed on probation for a period of five years without narcotics.

Wendell William White, M.D.—License restored; Dr. White was placed on probation for a period of five years with specified terms.

Nicolai N. Rilcoff, M.D.—In the matter of the accusation of Dr. Nicolai N. Rilcoff, this was continued to March 22, 1947. On March 23d, he was found guilty of unprofessional conduct as defined in Section 2392 of the Business and Professions Code. His license was suspended for a period of one year, after which he will be placed on probation for a period of five years.

News

"Solon Probe Group For Kern Hospital Recommended Licenses—A legislative subcommittee which has been investigating the administration of the county operated Kern General Hospital in Bakersfield recommended the enactment of a law requiring such institutions to obtain licenses from the state department of public health . . . The subcommittee, headed by Assemblyman C. Don Field of Los Angeles County, filed a 53-page report charging the Kern County Hospital with employing unlicensed doctors, one of whom was accused of selling donated blood and retaining the proceeds . . . Chairman Field said a copy of the report is being forwarded to the attorney general for 'proper action'. . .'It is incredible and amazing,' the report said, 'that a situation such as that disclosed by the evidence at the subcommittee's hearings could have existed in Kern County; that a score of unlicensed doctors would be hired as county employes, with the knowledge of the board of supervisors and of the medical director of the county hospital, and be permitted to practice medicine, in flagrant violation of our law'. . . The report noted that the Kern County district attorney has filed charges against Alfred F. Rhoden, accused of practicing without a California license, and that the State Board of Medical Examiners has suspended the license of Dr. Nicolai Rilcoff, former medical director of the hospital."—(Sacramento, California *Bee*, March 31, 1947.)

PHYSICAL EXAM EFFECTIVE TOOL FOR PLACEMENT OF EMPLOYEES

"The industrial physical examination is a tool which, when correctly used, is an effective instrument for the proper placement of employees," states F. E. Poole, M.D., of Glendale C,alif.

Discussing the objectives and methods of industrial physical examinations in the January 11 issue of *The Journal of the American Medical Association*, Dr. Poole writes that "generally, it is sufficient to determine that the worker has normal vision, hearing and use of the extremities and is free from communicable disease, serious disease of the heart or the lungs, hernia, deformity or any other condition which would be aggravated by employment.

"Depending on the needs of the specific industrial plant, this basic examination may be expanded in many ways; for example, in a plant where high noise levels are encountered, closer attention must be given the ears, while in a factory where much heavy lifting is done, special attention must be paid to the body structure, back and hernias."

Dr. Poole points to workmen's compensation laws and the responsibility of employers for the care of occupational injuries as instrumental in introducing physical examinations in industry. "This responsibility encouraged the attempts to weed out by examination all but the most physically fit workers, eliminating those with physical defects, who, it was thought, might have a higher accident frequency.

"This method did not result in the desired lessening of industrial accidents; it was found that freedom from physical defect is not necessarily synonymous with freedom from accident proneness. Physical standards were

(Continued on Page 60)

PHYSICAL EXAM EFFECTIVE TOOL FOR PLACEMENT OF EMPLOYEES

(Continued from Page 56)

placed so high in many instances, however, that workers physically substandard in some detail, yet perfectly capable of satisfactory employment in many occupations, were eliminated from the work force."

The author, therefore, suggests that any information transmitted to the personnel office should be for the one purpose of classifying the employee's ability to work. He recommends the following classification system:

Group 1: "Unlimited." Acceptable for any type of work.

Group 2: "Limited." If a physical handicap or defect is serious enough to limit a person's working ability, constitute a hazard at work, or be seriously aggravated by some type of work, such a person will be classified as limited and placed in one or more of the following classes, which are intended to describe in lay terms the type of work which he should avoid. The reason for the limitation is a confidential matter and of no practical interest to the sunpervisor as long as he is aware of the type of work prohibited.

Class I—No hazardous machinery

Class II—No heavy lifting

Slass III—Work at ground level only

Class IV—Avoid contact with or exposure to (agent or substance to be specified)

Class V—No extensive walking or standing

Class VI—Miscellaneous (this may be expanded to other classes as needed by the type of industry)

Group 3: "Severe Handicaps" involving special placement problems (as the blind). Transfers are not to be made without approval of the Medical Department.

Group 4: "Temporarily Unable to Work" because of a transitory condition or a correctible defect.

Group 5: "Rejection." Serious physical or mental disease or disability rendering the persons unfit for any work.

Physical examinations should continue at set intervals after the employee is hired, to prevent occupational disease. The author states that "education of the employee is an important part of the program for occupational disease control. Employees should not be kept in ignorance of the hazards involved in their work because of the employer's fear that this knowledge might induce them to bring unjust claims for imagined injury. It has been our experience that employee morale is improved when the workers are aware of the protection afforded by the continuing plant surveys and periodic examinations."

Blaise Pascal (1623-1662).—A body wraked with disease and a mind castigated by severe self-discipline, were Pascal's lifelong handicaps. He wore an iron-spiked girdle with which he prodded his ribs to ward off drowsiness. Frequently, he was subject to dizzy spells, after runaway horses had dragged his carriage over a bridge, leaving the wheels hanging precariously over a parapet of a steep cliff. His immortal "Pensées" were written while he was afflicted with neuralgia and other nervous disorders.—Warner's *Calendar of Medical History.*

COLDS COST AMERICAN PUBLIC BILLION DOLLARS EACH YEAR

"The common cold costs the American public more than a billion dollars each year," according to Noah D. Fabricant, M.D., a noted specialist in otolaryngology.

Writing in the current issue of *Hygeia*, health magazine of the American Medical Association, Dr. Fabricant states that "of all ailments, it is the most democratic, striking virtually every inhabitant in the United States at least once a year. No one is immune by virtue of his position or importance or can hope to go through adult life unescorted by sieges of the common cold."

Dr. Fabriant is now serving as Clinical Professor of Otolaryngology at the University of Illinois College of Medicine in Chicago.

"In this country there are three seasons of the year when colds are most prevalent," he writes. "One occurs in October and November, a second season early in January, and the third in March and April. The first epidemic of colds arrives with the first days of fall."

Evidence points to a virus as the cause of colds but bacteria produce the unpleasant symptoms. The author states that "at the time the earliest symptoms of the common cold appear, there may be some hope for aborting the malady. During the early stages one is often conscious of a sensation of dryness and burning in the back part of the nose and throat. This sensation often serves as an initial warning that the cold is taking hold. If you heed the preliminary warning, you will then consider medical action imperative.

"A steam kettle or a vaporizer should be used to supply moisture to the stricken upper respiratory passages. In addition, a warm room (temperature about 70 degrees) with a relatively high humidity, reduces nasal symptoms and often prevents complications in the throat and lower respiratory passages."

The author gives the following advice to persons with colds and reveals the fallacies of certain treatments:

"Rest in bed, and this cannot be emphasized enough, has stood the rigid test of time as a most sane and effective measure during the early stages of the common cold. . . .

"Various drugs are available if fever occurs during a cold. Among the most popular and most widely used are salicylates. . . .

"So widespread is the belief of the American public that the use of sodium bicarbonate (baking soda) or other alleged antacids is a preventive in the treatment of the common cold that it may really be called a part of American folklore. There is no scientific basis for the notion that sodium bicarbonate is of value in the treatment of colds. . . .

"To determine the value of cold vaccines, or 'cold shots' as they are popularly designated, numerous experiments have been made. One large eastern company interested in the problem of industrial absenteeism as it relates to the common cold and other acute respiratory infections realized, after considerable study, that vaccines give no evident protection against colds. Physicians conducting these experiments state that 'the indiscriminate use of cold vaccine now available is not the answer to the problem of industrial absenteeism due to acute respiratory infections.' Perhaps the future will see the introduction of a highly improved injection type of vaccine that really can produce results."

TRACE MUCOUS COLITIS, COLON DISORDER, TO NERVOUS SYSTEM

The present trend in medicine is to consider the nervous system as the origin of mucous colitis, a disorder of the colon, according to Harry Gauss, M.D., of Denver, Colo.

Writing in the current issue of *Hygeia*, health magazine of the American Medical Association, Dr. Gauss states that in this disease "the colon expresses the individual's conflict with the world in which he lives. Somewhere in his struggle for existence, or for power, the individual has encountered one or more rebuffs or frustrations. This results in a psychic conflict that is expressed as fear, worry, anxiety or other psychic states that are conveyed to the sympathetic nervous system of the bowel and result in derangements of the colon such as rumblings, excessive flatulence, localized or diffuse abdominal pain, diverse constitutional symptoms and the appearance of mucus in the stools."

The author points out that "attempts have been made to explain the occurrence of mucous colitis on other grounds than that of nervous origin. These attempts include errors in diet, nutrition, vitamin deficiency, allergy and other factors. These factors are not of much importance, since the removal or correction of them has little influence on the course of the disease."

A patient, according to Dr. Gauss, may develop any of the following symptoms of the disease: "Localized pain may occur anywhere in the abdomen, although it tends to be identified with the colon, especially the descending segment or that part which is just above the left hip bone and somewhat towards the middle of the body. Hyperacidity and heartburn in the pit of the stomach are

(Continued on Page 70)

TRACE MUCOUS COLITIS, COLON DISORDER, TO NERVOUS SYSTEM

(Continued from Page 68)

common. This heartburn is often relieved by soda or food and sometimes occurs when the stomach is empty so that it may suggest ulcers of the stomach. X-rays, however, will easily separate one from the other. . . . Excess gas is another distressing symptom of mucous colitis. These pains may be mild or sharp and knifelike.

"Constipation is common. . . . Numerous other symptoms that also may develop during the course of the disease include nausea, coated tongue, loss of appetite, offensive breath, tensional headaches, low blood pressure, insomnia, irritability, palpitation, and dizziness."

In this ailment the patient must be treated as well as the disease. However, the author states that "treatment is not limited to the psychic approach, although it is the important step. Other important procedures consist of rest in bed, which tends to relax the person as well as reduce his nutritional requirement. This is an aid to the digestive tract, since it is already overburdened by the disease process. Not all persons, however, respond well to bed rest. Some persons tend to become moody when left alone with their own thoughts, so these persons are better off up and about. Besides bed rest, various forms of relaxation, such as trips and vacations, and other forms of physical therapy may be employed.

"The diet, usually bland, should contain the essential vitamin, mineral, protein, fat, carbohydrate and energy requirements, with a minimum of roughage, from which all the known digestive irritants have been removed.

"Certain drugs are useful. These enable the physician to control symptoms, allay the anxiety of the patient, establish confidence in the program and make the patient more comfortable. The drugs commonly employed are sedatives and antispasmodics."

52 PLANS GRANTED SEAL OF ACCEPTANCE BY COUNCIL OF MEDICAL SERVICE

The Council on Medical Service of the American Medical Association announces that a total of 52 prepayment medical care plans have been granted the "Seal of Acceptance."

The most recent plans which were granted the right to use the seal are the Louisiana Physicians Service, Inc., New Orleans; New Hampshire-Vermont Physicians Service, Concord, N. H., and the 23 member bureaus of the Washington State Medical Bureau.

Louisiana Physicians Service, Inc., is a statewide plan sponsored by the Louisiana State Medical Society with offices in the Tulane Building, New Orleans. Frank Lais, Jr., is the executive director.

New Hampshire-Vermont Physicians Service is the result of the merging of New Hampshire Physicians Service, Concord, N. H., with Vermont Physicians Service, Rutland, Vt. The executive offices are located at Concord and the executive director is R. S. Spaulding. This is the first plan sponsored by the medical profession which covers the population of the two states under a single administrative office.

The standard under which a plan is granted the Seal of Acceptance require that it must first have the approval of the state medical society or, if local, it must be approved by the local medical society in the area in which it operates. The members of the medical profession must assume responsibility for the medical services included in the benefits. The plan should have no regulation which restricts free choice of a qualified doctor of medicine who is practicing in the locality covered by the plan and who is willing to give service under the conditions established. The method of giving the service must retain the personal, confidential relationship between the patient and the physician. These and other qualifications must be met by plans seeking the right to use the council's seal.

Of special interest regarding prepayment medical care plans on a nationwide basis is the fact that those with a large number of employees have expressed a desire to deal exclusively with plans which merit the council's Seal of Acceptance.

RESTRICTED USE OF SALT URGED FOR CONGESTIVE HEART FAILURE

Three Boston physicians advocate the restriction of salt in the diet with a liberal intake of fluid for patients with congestive heart failure, especially those with coronary and hypertensive heart disease, according to an article in the January 4 issue of *The Journal of the American Medical Association.*

The physicians, who are from the Massachusetts General Hospital, are Edwin O. Wheeler, Graduate Assistant in Medicine, William C. Bridges, Commonwealth Fund Research Fellow, 1945-46, and Paul D. White.

They point out that "with a few notable exceptions, casual limitation of salt and fluid has been the custom throughout the country, and generally more stress has been placed on the restriction of fluid than on that of salt."

When the heart is unable to fulfill its function adequately as a pump and supply sufficient circulation to all of the tissues of the body, such symptoms as shortness of breath, swelling of the legs and abdomen may result. To prevent this accumulation of fluid which produces swelling in the tissues, the physicians treated 50 patients with congestion due to heart diseases of all types during the last year and a half.

Of the 35 patients who followed the salt restricted diet faithfully, 13 did not show improvement, while 22 were better; of the latter group 10 showed great benefit. "In no instances were patients made worse by this therapy," state the authors.

Twenty of the 35 patients had hypertensive (caused by high blood pressure) and/or coronary heart disease. Eighteen of these showed improvement, in nine of whom it was pronounced.

The physicians warn that "there are certain precautions which must be carefully observed in following a diet low in sodium [salt]:

1. Salt, soda, or baking powder should not be used in the cooking or at the table. Substitutes for salt which contain sodium should not be used.

2. Sweet butter or butter that has been washed free of salt may be used. Bread and salad dressings must be prepared salt free. Canned foods, unless prepared salt free, should not be used.

3. Salty appetizers or salted foods, such as nuts, potato chips, sardines, olives, pickles and relishes, are to be guarded against. Cheese and smoked or salted meats are not permitted.

4. Medicines containing sodium should not be used against gas or indigestion. Calcium salts are helpful in this regard."

WARTIME EXPERIMENTS HAVE MADE MALARIA CONTROL A POSSIBILITY

Wartime developments can eradicate malaria in the United States within a decade and make it a negligible problem in tropical areas, according to Capt. James J. Sapero, Medical Corps, United States Navy.

Writing in the November 16 issue of *The Journal of the American Medical Association*, Captain Sapero, who is from Washington, D. C., cites another investigator who stated that with suitable organization, malaria could be eradicated "from the United States within the next decade, and that in many tropical areas, even though economically depressed, this disease, now of the greatest importance, may become in the next half century one of the least of public health problems."

The search for a curative drug during the war emergency led to many trials and errors. Quinine, for decades considered the most important drug in malaria treatment, was displaced by atabrine when most of the cinchona plantations fell into the hands of the enemy early in the war. Although atabrine had been known for some years before the war, overseas experience for the first time established it as an efficient and safe antimalarial. But it did not cure the disease.

This presented a serious problem for military doctors who had to find a cure for the stubborn South Pacific type of malaria caused by Plasmodium vivax. Captain Sapero states that "American infections caused by P. vivax terminated usually within a period of 18 months; South Pacific infections, in contrast, continued frequently on into the third year."

Finally, as a result of wide-scale research, chloroquine (SN-7618) was shown to be three times as powerful as atabrine, less poisonous, free from the stomach and intestinal intolerance caused by atabrine and without the skin-staining quality of this drug.

"Furthermore," states the author, "it rapidly controls clinical symptoms in both the P. vivax and the P. falciparum types of malaria and is curative in the latter."

In the course of the continued search for a cure for the South Pacific malaria, pamaquine and pentaquine (SN-13276) were discovered to be successful but too poisonous. Investigators are still searching for a nontoxic drug.

Another powerful weapon launched against malaria during the war was DDT. "Prior to World War II," writes Captain Sapero, "the main attack on anophelines [mosquitoes transmitting malaria] was almost solely confined to measures which would destroy larval forms. Measures against adult mosquitoes were difficult and infrequently attempted. With the introduction of DDT, however, the attack has become twofold, i.e., against both larvae and adults.

"Where there are large areas to cover, airplanes have proved effective for the dispersal of DDT. In the extensive trials conducted during the war, different types of planes were used, varying from the small cub plane which would carry only 27 gallons to large multimotored transport planes with a capacity of many hundreds of gallons. These wartime trials indicate that the airplane in the postwar period will serve as an important aid to malaria control, not only as a device for saving time and labor but also for the control of areas otherwise inaccessible.

"In the use of DDT to control adult mosquitoes, many promising possibilities are being explored. During the war military forces found that by impregnating bed nets, by spraying the inside of tents and other types of housing and, particularly, by spraying native quarters a

significant reduction of the adult mosquito population could be accomplished. The attack on adult mosquitoes means that malaria transmission in an uncontrolled area can be stopped far more readily than has ever before been possible. No longer is it necessary to wait for the natural mortality of infected adult insects, as was formerly the case when the attack was made exclusively against larvae. Even more promising are current experiments in which complete control is being attempted solely by adult kill. Such experiments, it is hoped, will prove that whenever larvicidal measures are impractical for reasons of cost or inaccessibility, effective control by adult eradication can nevertheless be achieved."

New Hour For Radio Show

"California Caravan" the radio show sponsored by the California Medical Association is now heard every Friday evening at 8:45 p.m. rather than at the original Saturday evening time. The same 17 Mutual Stations are being used.

VITAMIN B COMPLEX FRACTION EFFECTIVE FOR TICK FEVER

A drug, belonging to the vitamin B complex group, has been found highly effective in the treatment of Rocky Mountain spotted fever, a tick-borne disease, which is often severe and sometimes fatal, according to four investigators writing in the December 14 issue of *The Journal of the American Medical Association.*

This study was made through the cooperation of the Delaware, Memorial, St. Francis and Wilmington General Hospitals of Wilmington, Del. The investigators are Lewis B. Flinn, M.D., John W. Howard, M.D., Charles W. Todd, Ph.D., and Elvyn G. Scott, M.T.

The authors cite the Delaware State Board of Health which reported that, in the 10 year period from 1936 to 1945, inclusive, they were notified of 50 cases of Rocky Mountain spotted fever. Of those 50 cases, 14 were fatal, a mortality of 28 per cent.

A group of 21 untreated patients studied in the Wilmington, Del., area from 1938 to 1946 had a death rate of 24 per cent. Fifteen of these patients were under 40 years of age; two died—a mortality of 13 per cent. The authors state that "it is evident, therefore, that in this particular area Rocky Mountain spotted fever is of a fairly severe type."

A series of 10 patients with this disease were treated with para-aminobenzoic acid. Nine of the patients under 40 "responded dramatically," according to the authors.

Comparing these nine treated patients with the 13 untreated patients of the previous series, all under 40 years of age, the authors state: